KyHealth Choices

UPDATE

August 2006

Cost Sharing and Service Limits Monitored for Impact

New cost-sharing and limits for all for benefit plans became effective July 1, 2006. Cost sharing and limitations vary by benefit packages. However, the maximum amount of cost-sharing a member will pay is $225 per year for medical services and $225 per year for pharmacy services and will not exceed five percent of a family's income per quarter. The Department will be reviewing data on member utilization patterns and quality outcomes to ensure members are still receiving needed services.

Public Forum Set

Commissioner Glenn Jennings will be participating in every other month public forums entitled "Ask the Medicaid Commissioner". The forums will be held at the Health Services Auditorium in the CHR building, 275 East Main Street, Frankfort, Ky. The first forum is scheduled to be conducted on September 21, 2006 at 3 o'clock. This on-going series of forums are open to all *KyHealth Choices* members and guardians, advocacy organizations, providers and staff.

Consumer Directed Options Begin September 30, 2006

DMS continues to make progress toward implementing CDO in the most efficient and effective manner possible. The Department has partnered with the Division for Aging to administer the support broker and fiscal intermediary components of CDO. The AAA's will take on the role of Support Broker and the ADDs to be the Financial Management agency. The AAA's are being chosen due to their success in administering similar services.

The program will allow clients currently in one of the Medicaid waivers to volunteer to participate in the new program. If they choose to do so the Support Broker will assist them in developing a care plan, a financial plan and provide oversight to the hiring of caregivers and other required services.

Medicaid expects about 400-450 individuals will choose the new program during the first year. CDO will be implemented statewide without a cap to the number of participants.

Medicaid recipients enrolled in the HCBS waiver can begin enrollment in CDO by September 30, 2006. CDO will be operational for the SCL waiver by November 30, 2006 and the ABI waiver by January 2007.

Disease Management and Prevention Pilot Programs Created

In Partnership with local resources, Health Care Facilities, and state agencies, the Department for Medicaid Services provided numerous free health screenings around the state over the past five months. The screenings included testing glucose, cholesterol, and lipids. In addition, during the past year, the Department has designed and implemented nine Disease Management pilot programs and three Wellness and Prevention initiatives. For program and location information of pilot projects, please see the attached state map.

New Incentive Program Focusing on Prevention for Women's Health

Realizing the importance of preventive measures both for the physical health of an individual and for the fiscal health of the Department, *KyHealth Choices* initiated an incentive program in nine pilot counties, for women ages 21-64 who are Medicaid eligible, and complete a mammogram and/ or PAP test. The women can receive a $10 check for one test or $20 when both tests are completed

Appropriate Use of Atypical Antipsychotic and Behavioral Medications

The Department for Mental Health and Mental Retardation Services and the Department for Medicaid Services, in conjunction with Eli Lily, are negotiating the approval of a Comprehensive Neurosciences (CNS) program. The program, which has been highly successful in several other states, will assist physicians, clinicians and consumers to reduce the inappropriate use of antipsychotic and other behavioral drugs.

Prior Authorizations

On August 1, 2006, DMS began requiring prior authorization for some new services and also began utilizing InterQual, a clinical tool, in making some medical necessity decisions. Please visit our website at http://chfs.ky.gov/dms for a complete list.

Optimum Choices

The one area which remains unresolved for the *KyHealth Choices* Plan is the Optimum Choices benefit package for individuals with MR/DD. The Cabinet continues to push for approval of the 1115 waiver. However, the Centers for Medicare and Medicaid Services (CMS) is strongly encouraging the Commonwealth to seek the same outcomes and goals under one or more 1915 c waivers or the new Deficit Reduction Act (DRA). Staff continues to work with CMS to accomplish this goal. *The Cabinet will not support anything less than what was identified in the current 1115 Optimum Choices application.*

Enhanced Rate for Community Transitions

The enhanced rate for transitioning individuals from an ICF/MR to the community goes into effect on September 1, 2006. The rate is a flat rate of $125,000 and is an all inclusive rate for all

necessary services to maintain community inclusion. It is the responsibility of the provider to obtain the necessary services through either direct provision or contractual arrangements with certified SCL providers. The provider, direct or contractual, may only provide services for which they have been certified to provide. Services must be individualized to meet the unique needs of the recipient and identified on the individual service plan. For more information on qualified providers and the process to access the rate, please see the attached Enhanced Rate Update #3.

Money Follows the Person Grant

The Cabinet is applying for the Money Follows the Person Grant. The grant will cover individuals who are frail, elderly or disabled, and individuals with mental retardation/developmental disabilities (MR/DD) or who have an acquired brain injury (ABI) who choose to move from an institution to the community. A workgroup comprised of representatives from various advocacy agencies has been created to assist the Cabinet in drafting the grant.

Dental Benefit Changes

In the past few months the Department has been reviewing the dental regulations. The review has resulted in several new and exciting policy changes. On July 1, 2006, *KyHealth Choices* put in place a second Prophylaxis for Kentucky Medicaid members ages 20 and under. As of date of service 9/30/2006, Kentucky Medicaid members ages 20 and under will be allowed the second Comprehensive Oral Evaluation (D0150) in a twelve month period when billed in conjunction with a prophylaxis (D1110 or D1201). Effective August 15, 2006, there was a 30% increase in fees for some of the dental procedures provided to members ages 20 and under. Kentucky Medicaid has extended the definition of the emergency code (D0140) to include treatment for acute infections as well as other dental emergencies. As a result of the extended definition, Medicaid has added surgical extractions and incision and drainage codes to the list of covered services allowed with the emergency code D0140. This policy will go into effect date of service September 30, 2006.

Pharmacy Benefit Changes

The Department has made changes to the third tier pharmacy benefit. The five percent coinsurance on third tier non preferred brand drugs will be limited to $20 per prescription DMS will operationalize this change within three to four weeks. The $225 yearly out-of-pocket maximum will remain in effect.

KCHIP Enrollment

The Department will be monitoring KCHIP enrollment to ensure that the copayment and service limit changes to the program do not have an adverse impact on enrollment. Baseline data regarding ER, pharmacy and allergy testing has been developed to monitor the impact of these changes on utilization. The KCHIP advisory Council, comprised of providers, members and advocates, continues to meet on a quarterly basis to discuss and analyze the KCHIP program.

Department Applying for a New Brain Injury Grant

The Department is committed to submitting a "long term care" waiver for ABI that goes beyond rehabilitation to maintenance of daily living. The Cabinet has set a tentative deadline of late Fall 2006 for submission of this waiver.

In addition, the renewal application for the current ABI waiver is being drafted. To ensure input from consumers and providers, the Department pushed back the day of submission to September 15, 2006.

New Citizenship Documentation Requirements Being Monitored

To ensure a smooth process for the implementation of the new Citizenship Documentation Verification requirements under the DRA, the Cabinet has convened a small work group to monitor implementation and impact. The group, comprised of representatives from ARMS, the Department for Medicaid Services, the Department for Community Based Services, Vital Statistics and Health Policy, will continue to meet on a regular basis for the next few months to problem-solve any glitches in the roll-out of the new guidelines.

Mobile Mammography Coming to Eastern Kentucky

King's Daughters Hospital is partnering with the Department for Medicaid Services to provide Mobile Mammography. The van is scheduled for a one time visit to each of the following counties in mid September, Martin, Magoffin and Wolfe Counties. These counties were selected based on the lack of availability of this resource within the county. Each county health department has agreed to assist the Department by scheduling patients for the testing. The mobile van will travel to each county for one day and can serve up to 24 patients. Announcement posters are being distributed this month throughout those counties.

Regulation Update

A short summary of the status of outstanding regulations is attached with this electronic document. In addition, Kentucky Medicaid providers and members can access Medicaid program regulations on the Cabinet for Health and Family Services website, www.chfs.ky.gov/dms/current.htm. Medicaid providers can also access current information such as dates of provider workshops, provider letters and fee schedules on the *KyHealth Choices* website, http://chfs.ky.gov/dms/kyhealthchoices.htm.

Works in Progress

- ***Provider Credentialing***
  First Health, Coventry and the Department are working diligently to develop and efficient methodology for credentialing providers.

- ***Rates***
  Work continues through the Continuum of Care Committee to develop an enhanced service array for long term care which will be supported by reimbursement rates based on individual levels of acuity.

Interesting Medicaid Facts

- The typical Kentucky Medicaid member utilizes the emergency room 1.13 times each month for an average of $183.83. The most common diagnoses for ER usage are migraines and skin/diaper rashes. Far from that average, and prior to the implementation of *KyHealth Choices*, 1300 members visited the emergency room over five times or more in FY 04. Four of those visited the ER over 100 times and one individual visited 172 times. To curb the excessive usage by a small minority of individuals, *KyHealth Choices* now requires a 5% coinsurance for any ER visit deemed a non-emergency.

Frequently Asked Questions

1. **Does a provider need to request prior authorization for services even when the service limit is not reached?**

   a. Possibly. Prior authorization regulations do not change for services regardless of the status of the limitation. Service limits should not be viewed as a "free pass" for up to that number of services. Once a service limit is reached, the prior authorization criterion does not change. However the provider will need to submit notes that update the case, show progress with treatment and medical necessity.

2. **How will the bidding-out process for KCHIP and children's Medicaid services be implemented and how will it be evaluated as to cost-effectiveness and quality?**

   a. At this time, the Department has not conducted a financial analysis to determine if bidding out Family Choices will be cost effective. Once completed, and if deemed cost effective, then an RFP will be developed. However, DMS would retain all policy decisions and authority. Quality control measures would be implemented and monitored as a part of the contract. Such measures would include access to care, enrollment and retention, service utilization, and health outcomes. Baseline data would be gathered before awarding the contract and the winning contractor would have to meet or exceed established criteria.

3. **How will the Cabinet inform providers and recipients of the fact that services limits are "soft" and of the process to exceed them?**

   a. The Department has met with provider associations throughout the design and implementation of *KyHealth Choices* to ensure a smooth transition. The Department sent a letter dated May 15, 2006 informing providers of *KyHealth Choices*, outlining the four benefit packages and attaching a copy of the grids

for each benefits package. Another provider letter was sent on July 14, 2006 notifying providers that service limits had been created but that all would be subject to soft limits, meaning that the limits could be overridden by a prior authorization deeming the service medically necessary**.**

4. **How will providers know which recipients are exempt from co-payments and which have met the quarterly or annual cap?**

    a. Each member is subject to an annual expense of $225 maximum out of pocket for medical services and $225 maximum out of pocket for prescription drugs. The MMIS will track the copays to ensure that they are correctly applied. Providers may check the AVRS System at 1--800-807-1301 or via the internet at KyHealth Net.